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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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BOARD OF SPEECH/LANGUAGE PATHOLOGISTS, AUDIOLOGISTS AND HEARING AID DISPENSERS

APPLICATION FOR SPEECH/LANGUAGE PATHOLOGY LICENSE
INSTRUCTION SHEET

General Information

This section explains the types of Speech/Language Pathology licensure in Delaware.

- **Temporary** – If you have not completed your Clinical Fellowship (CF), you must apply for a Temporary Speech/Language Pathology license. The temporary license is good for one year, during which you should complete your CF and pass the national examination. The Board must approve any extension of the temporary license.

- **ASHA Certification** – If you have *completed* your CF, *passed* the national examination, and *received* your ASHA certification, you may apply for a permanent Speech/Language Pathology license based on ASHA certification.

Requirements for *All* Applicants

The following requirements apply to all applicants regardless of whether applying for a permanent or temporary license:

☐ Submit completed, signed and notarized *Application for Speech/Language Pathology Licensure*.

☐ Enclose fee by check or money order made payable to "State of Delaware." If you are applying for a Temporary license, enclose the temporary license fee. Otherwise, enclose the processing fee for Speech/Language Pathology.

☐ If you have ever held a license in another jurisdiction, arrange for the Board office to receive verification of licensure from each jurisdiction where you have held a license, sent *directly* from the jurisdiction to the Board office. These verifications are required even if you previously submitted verifications in connection with an earlier application.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.

- *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Additional Requirements for Applicants for Temporary Licensure

If you are applying for a Temporary license, these items are also required. Note that you must submit your exam scores within one year of receiving your Temporary license.

☐ Arrange for the Board office to receive an official transcript from an accredited college or university, sent *directly* from the school to the Board office.
- The transcript must show that that you earned at least a master's degree or its equivalent with major emphasis in speech-language pathology, communication disorders or speech-language and hearing science.
- If the final transcript showing your degree is not yet available, arrange for the Board office to receive a letter from a school official attesting to the degree that you will receive. Although the Board will review your application with only this letter, the Board office will *not* issue the temporary license until it receives the final transcript.

☐ Arrange for the Board office to receive a letter from your practicum supervisor, sent directly from the supervisor to the Board office, showing that you have completed at least 400 clock hours of supervised clinical practicum at the appropriate level. See Sections 2.2 and 2.5.1.3.1 of the Board's Rules and Regulations.

☐ Arrange for the Board office to receive a signed, completed *Clinical Fellowship Plan* form.
- Your clinical supervisor must be a Delaware-licensed Speech/Language Pathologist.
- Do not begin your Clinical Fellowship until your temporary license is issued.

***Additional* Requirements for Applicants by ASHA Certification**

If you are applying for a permanent Speech/Language Pathology license by ASHA certification, the following are required in addition to the documentation in the **Requirements for All Applicants** section above.

☐ Submit a copy of your ***current*** ASHA certification card.

☐ Arrange for the Board office to receive an official score report showing that you passed the *Praxis*™ Speech/Language Pathology national examination, sent directly from the testing service to the Board office.
- If you did not order a score report for Delaware when you took the exam, click Praxis: For Test Takers: Scores to order an additional score report.

☐ If you did not previously submit a transcript in connection with an application for a Delaware Temporary license, arrange for the Board office to receive an official transcript from an accredited college or university, sent *directly* from the school to the Board office.
- The transcript must show that that you earned at least a master's degree or its equivalent with major emphasis in speech-language pathology, communication disorders or speech-language and hearing science.

☐ If you did not previously submit documentation of your clinical practicum in connection with an application for a Delaware Temporary license, arrange for the Board office to receive a letter from your practicum supervisor, sent directly from the supervisor to the Board office, showing that you have completed at least 400 clock hours at the appropriate level. See Sections 2.2 and 2.5.1.3.1 of the Board's Rules and Regulations.

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APPLICATION FOR SPEECH/LANGUAGE PATHOLOGY LICENSE

TYPE OF APPLICATION

1. Select the type of license you are applying for.

   ☐ Temporary – I have not completed a Delaware Clinical Fellowship.

   ☐ ASHA Certification – I have completed my Clinical Fellowship and passed the national examination.
   Do you hold a Delaware Temporary license? Yes ☐ No ☐ If yes, enter the license number: **O4 -** _____

IDENTIFYING AND CONTACT INFORMATION – *All* applicants complete this section.

2. Full Name: _____ _____ _____
   Last First Middle

3. Other Names Used: _____ _____ _____

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____
   Home Work

7. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   - If yes, enter your SSN: _____
   - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

EDUCATION – All applicants complete this section.

8. Enter the following information about your speech/language pathology education:

COLLEGE/UNIVERSITY	LOCATION	MAJOR	DEGREE	YEAR DEGREE RECEIVED

If you are applying for a Temporary license, arrange for the Board office to receive an official transcript from an accredited college or university, sent *directly* from the school to the Board office.

9. Have you passed the ***Praxis*™ Speech/Language Pathology** national examination? Yes ☐ No ☐

   If you are applying for a Temporary license, you have a year to pass the national examination. When you have passed the exam, arrange for the Board office to receive an official score report sent directly from the testing service to the Board office.

CERTIFICATION & LICENSURE HISTORY – *All* applicants complete this section.

10. Do you hold current ASHA certification? Yes ☐ No ☐ **If yes, submit a copy of your current ASHA certification card.**

11. Are you (*or have you ever been*) licensed in any other jurisdiction? Yes ☐ No ☐ If yes, enter the following information about *each* license:

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE	STATUS (e.g., active)

   Arrange for *each* jurisdiction listed to send a verification of licensure *directly* to the Board office.

CLINICAL PRACTICUM AND FELLOWSHIP PLAN – *Only* applicants for Temporary license complete this section.

12. Have you completed 400 clock hours of supervised clinical practicum at the appropriate level? Yes ☐ No ☐ If yes, enter name of clinical practicum supervisor: _____

    Arrange for the Board office to receive a letter from your practicum supervisor, sent directly from the supervisor to the Board office, attesting that you have completed the required hours at the appropriate level.

13. Enter the following information about the clinical supervisor for your Clinical Fellowship.

    Name: _____ Delaware License: **O1-**_____

    Arrange for the Board office to receive a signed, completed *Clinical Fellowship Plan* form, sent directly from the clinical supervisor to the Board office.

DISCLOSURES – *All* applicants complete this section.

14. Are any unresolved complaints pending against you in any jurisdiction? Yes ☐ No ☐ **If yes, submit a letter a letter fully explaining. Include copies of all appropriate records.**

15. Have you ever had your license or certificate to practice speech language pathology, audiology or hearing aid dispensing suspended, revoked, or subject to other disciplinary action in any jurisdiction? Yes ☐ No ☐ **If yes, submit a letter fully explaining. Enclose copies of all relevant records.**

16. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐ **If yes, submit a letter fully explaining the incident resulting in the charges. In addition, arrange for the Board office to receive a certified copy of your criminal history record.**

17. Have you *ever* excessively used or abused drugs (including alcohol, narcotics, or chemicals)? Yes ☐ No ☐ **If yes, submit a letter fully explaining. Enclose copies of all relevant records.**

18. Do you have any impairment related to drugs or alcohol that would limit your practice of speech/language pathology, audiology or hearing aid dispenser? Yes ☐ No ☐ **If yes, submit a letter fully explaining. Enclose copies of all relevant records.**

DUTY TO REPORT – *All* applicants complete this section.

19. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

20. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

21. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to report if you have evidence that a practitioner has violated the Code of Ethics (Section 9.0 of the Rules and Regulations) or other law or regulation.

    I certify that I have read and understand Section 9.2.1.6 of the Rules and Regulations and understand my *duty to report*. Yes ☐ No ☐

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to report if you if you have evidence that a person is practicing the profession without a license in violation of 24 *Del. C*. §3707.

    I certify that I have read and understand Section 9.3.2.2 of the Rules and Regulations and understand my *duty to report*. Yes ☐ No ☐

To assure that your application will be reviewed at the Board's next meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six months of filing may be considered abandoned and discarded.

When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I swear that I am the person who executed this application; that the statements herein contained are true in every respect, that I have not suppressed or withheld information that might affect this application; that I will abide by the ethical standards of the profession; and that I have read and understand this statement.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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CLINICAL FELLOWSHIP PLAN (CF)

Applicants for a Temporary Speech/Language Pathology license must arrange for the Board office to receive this *Clinical Fellowship Plan* form signed by both the applicant and the clinical fellowship supervisor. The clinical fellowship supervisor must be a Delaware-licensed Speech/Language Pathologist. If more than one clinical supervisor will supervise the applicant, submit a form from ***each*** supervisor. Both the applicant (clinical fellow) and the clinical fellowship supervisor should retain a copy of this plan. Do not begin your Clinical Fellowship until your temporary license is issued.

INFORMATION ABOUT CLINICAL FELLOW

1. Full Name: _____ (Last) _____ (First) _____ (Middle)
2. Mailing Address: _____
   _____ (City) _____ (State) _____ (Zip)
3. Phone: _____ (Home) _____ (Work) Email: _____

INFORMATION ABOUT CLINICAL FELLOWSHIP SUPERVISOR

4. Full Name: _____ (Last) _____ (First) _____ (Middle)
5. Mailing Address: _____
   _____ (City) _____ (State) _____ (Zip)
6. Phone: _____ (Work) _____ (Cell) Email: _____
7. Delaware License Number: O1 - _____

CLINICAL FELLOWSHIP SETTING

8. Facility Name: _____
9. Mailing Address: _____
   _____ (City) _____ (State) _____ (Zip)
10. Phone: _____ _____ Email: _____
11. Anticipated CF Start Date (month/day/year): _____ Anticipated CF End Date (month/day/year): _____
12. Is this registration agreement for only a portion of clinical fellowship? Yes ☐ No ☐

CLINICAL FELLOWSHIP PROFESSIONAL EXPERIENCE

13. Enter the length of the clinical fellowship experience and number of hours per week:

    ☐ 36 weeks of full-time professional employment of at least 30 hours per week.
    ☐ 48 weeks of part-time professional employment of at least 25 hours per week.

14. Will the clinical fellow spend at least 80% of the clinical fellowship week in direct client contact (including assessment/diagnosis/evaluation, screening, habilitation/rehabilitation) and activities related to client management? Yes ☐ No ☐

CLINICAL FELLOWSHIP SUPERVISION

15. Both the clinical fellow and clinical fellowship supervisor certify the following:
    - There will be at least 36 supervisory activities during the entire clinical fellowship, including 18 hours of on-site observation and 18 other monitoring activities.
    - Clinical fellowship supervision will be divided equally among three segments. During each one-third segment of the clinical fellowship, there will be at least 6 hours of on-site observation and at least one other monitoring activity per month. Yes ☐ No ☐

SUPERVISOR AGREEMENT

- I have read, discussed, and agreed upon all sections listed above. I have read the ASHA Clinical Fellowship Supervisor's Responsibilities.
- I agree to conduct one formal evaluation during each one-third segment of the clinical fellowship.
- I agree to approve/disapprove, sign, and submit proof of completion, either a copy of the ASHA Clinical Fellowship Report or a letter of verification, to the Board office at least 30 days before the clinical fellow's Temporary license expires.
- I agree to fulfill this responsibility even if I am not able to approve the clinical fellowship experience.

Signature of Supervisor: _____ Date: _____

CLINICAL FELLOW AGREEMENT

- I have read, discussed, and agreed upon all sections listed above.
- I have verified that my supervisor holds a current Delaware license in the area in which I am seeking certification. I further agree to assume full responsibility for an invalid clinical fellowship experience if it is later determined that this is not correct.
- I have read and agree to abide by the Code of Ethics listed in the Board's Rules and Regulations.

Signature of Clinical Fellow: _____ Date: _____